ALTA
ORTHOPAEDICS

REQUEST FOR RELEASE OF MEDICAL RECORDS

Please allow 5-7 business days to process the request. CD's for X-rays are $10.00 payable upon request.

Date of request:	Patient's Name:	
Date of Birth:	Patient's phone #:	Last 4 of SS#:

Patient's Address:

I, the undersigned, authorize and request Alta Orthopaedics to release information to:

❍ Myself ❍ Name of practice or Doctor: _____ ❍ Other: _____

Address: _____ Phone #: _____

Delivery Method

❍ Mail - Address:

❍ Fax - Number:

❍ Email (patient only):

❍ Pick up at office: ❍ Santa Barbara - 511 Bath Street, Santa Barbara, CA ❍ Solvang - 2027 Village Lane, Suite 101, Solvang, CA

Information to be Released

Covering the periods of Health Care from (date) ____/____/____ to (date) ____/____/____

❍ X-rays: Please pay fee of $10.00 per disc. ❍ Paid:

Please indicate if for: ❍ PC *or* ❍ Mac | Please specify: ❍ I need all x-rays *or* ❍ only:

❍ Medical records: ❍ Work Comp (Injury date:) ❍ Private *or* ❍ ALL

❍ Billing records: ❍ Work Comp (Injury date:) ❍ Private *or* ❍ ALL

Drug and/or Alcohol Abuse, Psychiatric, Psychological Care, and/or HIV/AIDS Records Release

I understand that my medical or billing record may contain information in reference to drug and/or alcohol abuse, psychiatric care, psychological care, sexually transmitted disease, Hepatitis B or C testing, HIV/AIDS testing and/or treatment, and/or other sensitive information, I agree to its release.

Re-Disclosure

I understand that once information is released to the above named person or persons, my information may be subject to re-disclosure. I understand that once information is released, it may be re-disclosed by the recipient and no longer protected by federal privacy regulations. I understand that I do not have to sign this authorization, and my treatment or payment for services will not be denied if I do not sign this form unless it is for research-related treatments or provided soley to give information to a third party as specified under Purpose of Request. I can inspect or copy the protected health information to be used or disclosed. I am advised to request a copy of this signed release form for my records. I authorize the Center to use and disclose the protected health information specified above.

Signature _____ Date ____/____/____

Printed Name _____

If not the patient, please indicate your relationship to the patient: _____

Santa Barbara
511 Bath Street
Santa Barbara, CA 93101
(805) 963-9377

Solvang
2027 Village Lane, Suite 101
Solvang, CA 93463
(805) 688-8821

www.altaortho.com

FOR OFFICE USE ONLY: Date completed_____ By_____